Alta Health & Life Insurance Company
1 Centennial Avenue, P.O. Box 1326, Piscataway, NJ 08855-1326

A Statement of Health Made to Obtain Group Insurance
(ADULT FORM)

Please retain copy for your records. Please Print. Press firmly with ball point pen.

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE'S NAME (*First, MI, Last*)	**EMPLOYER NASA**	NASA CENTER AT WHICH EMPLOYED	
EMPLOYEE'S ADDRESS (*Street*)	**GROUP POLICY NO.**	**INSURANCE CLASS**	**AMOUNT OF COVERAGE**
CITY STATE ZIP CODE	**GL-661**		
SPOUSE'S NAME (*First, MI, Last*)	**GD-661**		

CHECK ONE:

☐ I am already insured under the Policies and now request dependent life insurance coverage for my spouse also.
☐ I am not insured under the Policies and now request coverage of myself only.
☐ I am not insured under the Policies and now request coverage for myself and dependent life insurance coverage for my spouse.

TO BE COMPLETED BY EMPLOYEE *(AND SPOUSE IF DEPENDENT LIFE REQUESTED)*

	1. Date of Birth	2. Place of Birth	3. Height (*in shoes*)	4. Weight (*with clothes*)
EMPLOYEE			ft. in.	lbs.
SPOUSE			ft. in.	lbs.

If the answer to any of the following is "yes," give details where indicated below.
Has any person above for whom coverage is now being requested ever had or been told he (or she) had, or been treated for any of the following:

	YES	NO
1. Pleurisy, blood splitting, or other lung disorder?	☐	☐
2. High blood pressure, heart murmur, pain or pressure in the chest, or any disorder of the heart or arteries?	☐	☐
3. Any blood, thyroid, glandular or breast disorder?	☐	☐
4. Albumin, sugar, blood or pus in the urine?	☐	☐
5. Any disorder of kidneys, bladder, generative organs, or syphilis?	☐	☐
6. Any disorder of stomach, gall bladder, liver, intestine, appendix or rectum?	☐	☐
7. Nervous breakdown or other disorder of nervous system, eyes or ears?	☐	☐
8. Any bone or joint disorder, rheumatism or gout?	☐	☐
9. Any impairment of sight or hearing or any physical or mental defects or impairment of any kind?	☐	☐
10. A hernia or other physical defect?	☐	☐
11. Any other disease, accident or operation?	☐	☐

	YES	NO
12. Has each person above for whom coverage is now being requested ever been examined for or made application to any insurance company for life, accident or health insurance without receiving the exact policies applied for; or been declined for reinstatement or renewal of any policy?	☐	☐
13. Been associated with anyone ill with tuberculosis during the last year?	☐	☐
14. Ever had or been advised to have a surgical operation for any reason not already mentioned?	☐	☐
15. Ever been in a hospital, asylum, sanitarium or other institution for observation, treatment or diagnosis for any reason not already mentioned?	☐	☐
16. Consulted or been treated by a physician or practitioner during the past five years?	☐	☐
17. For female lives only: Are you now pregnant?	☐	☐
18. Are you now in good health? If not, give details	☐	☐

Give details here for all questions checked "Yes" above.

No.	Treatment Given To	Condition	Dates	Treatment & Results	Phys. or Hosp.	Address
			to			
			to			
			to			
			to			
			to			

I acknowledge that the above statements and answers are true and complete to the best of my knowledge and shall be used as a basis for underwriting any coverage that may be granted. I also acknowledge that the Insurance Company has furnished me a copy of this instrument containing my answers, statements and explanations.

DATED AT (*Place*)	ON (*Date*)	If coverage is being requested for spouse, spouse **must** sign here. X

I acknowledge that the above statements and answers are true and complete to the best of my knowledge and shall be used as a basis for underwriting any coverage that may be granted. I also acknowledge that the Insurance Company has furnished me a copy of this instrument containing my answers, statements and explanations.

DATED AT (*Place*)	ON (*Date*)	In all cases, employee **must** sign here. X

GPO-120-625G (NASA) (2/00)

AUTHORIZATION

Please give to Alta Health & Life Insurance Company all information it may request regarding the medical history and physical condition of _____
(Insert Name of Person to be Examined)

A photostatic copy of this authorization shall be considered as valid as the original. Thank you for your courtesy.

ADDRESS	Signature of Emp. or Dependent who completed above statements

Attached to GPO-120-625G (NASA) (2/00)